The People of the State of Michigan enact:

Repeal of §§ 123.111 to 123.130.

Enacting section 1. 1870 (Ex Sess) PA 5, MCL 123.111 to 123.130, is repealed.

This act is ordered to take immediate effect.
Approved May 8, 2002.
Filed with Secretary of State May 9, 2002.

[No. 299]

(SB 1061)

AN ACT to repeal 1923 PA 60, entitled "An act to authorize the board of supervisors of any county of this state, severally, or in conjunction with the legislative body or board of any 1 or more cities or villages having a population in excess of 5,000 according to the last official census to establish and operate a public agricultural produce market or markets or sell, exchange or abandon the same," (MCL 46.101 to 46.104).

The People of the State of Michigan enact:

Repeal of §§ 46.101 to 46.104.

Enacting section 1. 1923 PA 60, MCL 46.101 to 46.104, is repealed.

This act is ordered to take immediate effect.
Approved May 8, 2002.
Filed with Secretary of State May 9, 2002.

[No. 300]

(SB 1063)

AN ACT to amend 1981 PA 97, entitled "An act to permit the state to approve and make eligible for participation under this act local bonds or other obligations upon application of a county, city, village, township, or charter township; to prescribe the powers and duties of certain state agencies; to provide for the application of certain state shared revenues for payment on distributable aid obligations; and to prescribe certain other matters relating to the bonds and other obligations and state shared revenues," by amending section 10 (MCL 141.1030), as amended by 1987 PA 281; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

141.1030 Pledge and lien on distributable aid.

Sec. 10. (1) The pledge and lien on distributable aid created by this act in favor of the holder of a distributable aid obligation may be on a parity with any pledge or application of distributable aid as security for obligations of a municipality under a contract or proceedings authorized by law after July 14, 1981 permitting the pledge or application of

distributable aid regardless of whether that contract or proceedings are subsequently declared invalid, illegal, unenforceable, disaffirmed, or otherwise terminated in whole or in part. However, any obligations to be incurred on a parity basis shall meet the requirements for participation eligibility under section 5, and the distributable aid respecting these obligations shall be paid, retained, or otherwise treated in accordance with section 6, and these obligations shall be entitled to all the benefits of this act.

(2) The pledge and lien on distributable aid created by this act in favor of the holder of a distributable aid obligation shall be superior to a pledge or lien on the distributable aid created by 1957 PA 185, MCL 123.731 to 123.786; the drain code of 1956, 1956 PA 40, MCL 280.1 to 280.630; and the county public improvement act of 1939, 1939 PA 342, MCL 46.171 to 46.188. The pledge and lien on distributable aid created by this act in favor of the holders of distributable aid obligations shall be superior to a pledge or lien on the distributable aid created after July 15, 1981, under 1955 PA 233, MCL 124.281 to 124.294; and the municipal finance act, 1943 PA 202, MCL 131.1 to 139.3, or any other law.

(3) A municipality may pledge and assign distributable aid for other obligations of the municipality authorized by law after July 14, 1981. However, the maximum debt service on these other outstanding obligations, together with the maximum debt service on outstanding distributable aid obligations in any fiscal year, shall not exceed the amount permitted under section 5 of this act.

(4) The restrictions prescribed by this act do not apply to obligations secured by either of the following:

(a) A pledge of distributable aid pursuant to statutory authorization that expressly permits a general pledge of distributable aid subject only to constitutional limitation.

(b) A pledge of distributable aid pursuant to statutory authorization that expressly excludes the pledge or the obligation from the provisions of this act.

(5) Beginning March 1, 2002, a municipality shall not issue or refund an obligation under this act.

Repeal of §§ 141.1021 to 141.1030; effective date of repeal.

Enacting section 1. The Michigan municipal distributable aid bond act, 1981 PA 97, MCL 141.1021 to 141.1030, is repealed effective January 1, 2010.

This act is ordered to take immediate effect.
Approved May 8, 2002.
Filed with Secretary of State May 9, 2002.

[No. 301]

(SB 1065)

AN ACT to amend 1957 PA 206, entitled "An act to authorize 2 or more counties, cities, townships and incorporated villages, or any combination thereof, to incorporate an airport authority for the planning, promoting, acquiring, constructing, improving, enlarging, extending, owning, maintaining and operating the landing, navigational and building facilities necessary thereto of 1 or more community airports; to provide for changes in the membership therein; to authorize an authority or the counties, cities, townships and incorporated villages that form an authority to levy taxes for such purposes; to provide for the operation and maintenance and issuing notes therefor; to authorize condemnation

proceedings; and to prescribe penalties and provide remedies," by amending section 9 (MCL 259.629), as amended by 1982 PA 312.

The People of the State of Michigan enact:

259.629 Airport authority board; borrowing money and issuing notes; maturity; purpose; resolution; notes issued subject to §§ 141.2101 to 141.2821.

Sec. 9. The airport authority board operating any airport under the provisions of this act, by resolution adopted by a majority vote of the entire governing board, may borrow money and issue notes, maturing not more than 1 year from the date of their issuance. Borrowing pursuant to this section shall be for the purpose of meeting current expenses of operation and maintenance of the airport. The resolution shall provide for the pledging of income and revenues of the airport authority not previously pledged for the payment of the notes and shall also provide for a special sinking fund into which there shall first be paid, as collected, a sufficient sum from the revenues of the airport authority pledges to retire both the principal and interest of the notes at maturity. The resolution may also provide for the pledging of other assets of the airport authority as additional security for the payment of the notes. Notes issued under this section are subject to the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821.

This act is ordered to take immediate effect.
Approved May 8, 2002.
Filed with Secretary of State May 9, 2002.

[No. 302]

(SB 1066)

AN ACT to amend 1986 PA 157, entitled "An act to help stimulate the expansion of international export markets of state products and services; to provide for the creation of the Michigan export development authority and to establish its board of directors; to prescribe the powers and duties of the authority and of the board; to provide for the issuance of, and certain terms and conditions of, bonds; to exempt bonds from certain taxes; to prescribe the powers and duties of certain state officers; and to provide for the creation of certain funds and for the funding of the creation and operation of the authority," by amending section 10 (MCL 447.160), as amended by 1990 PA 304.

The People of the State of Michigan enact:

447.160 Bonds and notes generally.

Sec. 10. (1) Bonds issued under this act may be executed and delivered at any time, may be issued as a single issue or from time to time as several issues, may be in the form and denominations, may be in coupon or registered form, may be payable in installments and at such time or times not exceeding 30 years from their date, may be subject to the terms of redemption, may be payable at such place or places, may bear interest at the rate or rates as may be set, reset, or calculated from time to time, or may bear no interest and may contain provisions not inconsistent with this act, all of which shall be provided in the resolution of the authority authorizing the bonds.

(2) Bonds issued under the authority of this act may be sold at public or private sale at the price and in the manner and from time to time as may be determined by the authority to be most advantageous. The authority may pay all expenses, premiums, insurance premiums, and commissions that the authority considers necessary or advantageous in connection with the authorization, sale, and issuance of the bonds from proceeds of the bonds.

(3) Bonds or notes issued by the authority are subject to the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821. The bonds issued by the authority are not required to be registered. A filing of a bond of the authority is not required under the uniform securities act, 1964 PA 265, MCL 451.501 to 451.818.

This act is ordered to take immediate effect.
Approved May 8, 2002.
Filed with Secretary of State May 9, 2002.

[No. 303]

(HB 4057)

AN ACT to amend 1978 PA 368, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," by amending the title and section 20161 (MCL 333.20161), the title as amended by 1998 PA 332 and section 20161 as amended by 2000 PA 253, and by adding section 20173.

The People of the State of Michigan enact:

TITLE

An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commis-

sions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates.

333.20161 Fees for health facility and agency licenses and certificates of need; surcharge; fee for provisional license or temporary permit; fee to recover cost of proficiency evaluation samples; fee for reissuance of clinical laboratory license; cost of licensure activities; application fee for waiver under § 333.21564; travel expenses; fees for licensure or renewal under part 209; deposit of fees; use of quality assurance assessment fee; "medicaid" defined.

Sec. 20161. (1) The department shall assess fees for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Except as otherwise provided in this article, fees shall be paid in accordance with the following fee schedule:

(a) Freestanding surgical outpatient facilities	$238.00 per facility.
(b) Hospitals	$8.28 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$2.20 per licensed bed.
(d) Homes for the aged	$6.27 per licensed bed.
(e) Clinical laboratories	$475.00 per laboratory.
(f) Hospice residences	$200.00 per license survey; and $20.00 per licensed bed.
(g) Subject to subsection (13), quality assurance assessment fee for nongovernmentally owned nursing homes and hospital long-term care units	an amount resulting in not more than a 7% increase in aggregate medicaid nursing home and hospital long-term care unit payment rates, net of assessments, above the rates that were in effect on April 1, 2002.

(2) If a hospital requests the department to conduct a certification survey for purposes of title XVIII or title XIX of the social security act, the hospital shall pay a license fee surcharge of $23.00 per bed. As used in this subsection, "title XVIII" and "title XIX" mean those terms as defined in section 20155.

(3) The base fee for a certificate of need is $750.00 for each application. For a project requiring a projected capital expenditure of more than $150,000.00 but less than $1,500,000.00, an additional fee of $2,000.00 shall be added to the base fee. For a project requiring a projected capital expenditure of $1,500,000.00 or more, an additional fee of $3,500.00 shall be added to the base fee.

(4) If licensure is for more than 1 year, the fees described in subsection (1) are multiplied by the number of years for which the license is issued, and the total amount of the fees shall be collected in the year in which the license is issued.

(5) Fees described in this section are payable to the department at the time an application for a license, permit, or certificate is submitted. If an application for a license, permit, or certificate is denied or if a license, permit, or certificate is revoked before its expiration date, the department shall not refund fees paid to the department.

(6) The fee for a provisional license or temporary permit is the same as for a license. A license may be issued at the expiration date of a temporary permit without an additional fee for the balance of the period for which the fee was paid if the requirements for licensure are met.

(7) The department may charge a fee to recover the cost of purchase or production and distribution of proficiency evaluation samples that are supplied to clinical laboratories pursuant to section 20521(3).

(8) In addition to the fees imposed under subsection (1), a clinical laboratory shall submit a fee of $25.00 to the department for each reissuance during the licensure period of the clinical laboratory's license.

(9) Except for the licensure of clinical laboratories, not more than half the annual cost of licensure activities as determined by the department shall be provided by license fees.

(10) The application fee for a waiver under section 21564 is $200.00 plus $40.00 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses shall be calculated in accordance with the state standardized travel regulations of the department of management and budget in effect at the time of the travel.

(11) An applicant for licensure or renewal of licensure under part 209 shall pay the applicable fees set forth in part 209.

(12) The fees collected under this section shall be deposited in the state treasury, to the credit of the general fund.

(13) The quality assurance assessment fee collected under subsection (1)(g) and all federal matching funds attributed to that fee shall be used only for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment fee and all federal matching funds attributed to that fee shall be used to maintain the increased per diem medicaid reimbursement rate increases as provided for in subdivision (e). Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment fee and participate in the medicaid program are eligible for increased per diem medicaid reimbursement rates under this subdivision.

(b) The quality assurance assessment fee shall be implemented on the effective date of the amendatory act that added this subsection.

(c) The quality assurance assessment fee is based on the number of licensed nursing home beds and the number of licensed hospital long-term care unit beds in existence on July 1 of each year, shall be assessed upon implementation pursuant to subdivision (b) and

subsequently on October 1 of each following year, and is payable on a quarterly basis, the first payment due 90 days after the date the fee is assessed.

(d) Beginning October 1, 2007, the department shall no longer assess or collect the quality assurance assessment fee or apply for federal matching funds.

(e) Upon implementation pursuant to subdivision (b), the department of community health shall increase the per diem nursing home medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment fee is assessed and collected, the department of community health shall maintain the medicaid nursing home reimbursement payment increase financed by the quality assurance assessment fee.

(f) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment fee qualifies for federal matching funds.

(g) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection (1)(g), the department of community health may assess the nursing home or hospital long-term care unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(h) The medicaid nursing home quality assurance assessment fund is established in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment fee with the state treasurer for deposit in the medicaid nursing home quality assurance assessment fund.

(i) Neither the department of consumer and industry services nor the department of community health shall implement this subsection in a manner that conflicts with 42 U.S.C. 1396b(w).

(j) The quality assurance assessment fee collected under subsection (1)(g) shall be prorated on a quarterly basis for any licensed beds added to or subtracted from a nursing home or hospital long-term care unit since the immediately preceding July 1. Any adjustments in payments are due on the next quarterly installment due date.

(k) In each fiscal year governed by this subsection, medicaid reimbursement rates shall not be reduced below the medicaid reimbursement rates in effect on April 1, 2002 as a direct result of the quality assurance assessment fee collected under subsection (1)(g).

(*l*) The amounts listed in this subdivision are appropriated for the department of community health, subject to the conditions set forth in this subsection, for the fiscal year ending September 30, 2003:

MEDICAL SERVICES		
Long-term care services	$	1,469,003,900
Gross appropriation	$	1,469,003,900
Appropriated from:		
Federal revenues:		
Total federal revenues		814,122,200
Special revenue funds:		
Medicaid quality assurance assessment		44,829,000
Total local revenues		8,445,100
State general fund/general purpose	$	601,607,600

(14) As used in this section, "medicaid" means that term as defined in section 22207.

333.20173 Nursing home, county medical care facility, or home for the aged; criminal history check of employment applicants; definitions.

Sec. 20173. (1) Except as otherwise provided in subsection (2), a health facility or agency that is a nursing home, county medical care facility, or home for the aged shall not employ, independently contract with, or grant clinical privileges to an individual who regularly provides direct services to patients or residents in the health facility or agency after the effective date of the amendatory act that added this section if the individual has been convicted of 1 or more of the following:

(a) A felony or an attempt or conspiracy to commit a felony within the 15 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract.

(b) A misdemeanor involving abuse, neglect, assault, battery, or criminal sexual conduct or involving fraud or theft against a vulnerable adult as that term is defined in section 145m of the Michigan penal code, 1931 PA 328, MCL 750.145m, or a state or federal crime that is substantially similar to a misdemeanor described in this subdivision, within the 10 years immediately preceding the date of application for employment or clinical privileges or the date of the execution of the independent contract.

(2) Except as otherwise provided in this subsection and subsection (5), a health facility or agency that is a nursing home, county medical care facility, or home for the aged shall not employ, independently contract with, or grant privileges to an individual who regularly provides direct services to patients or residents in the health facility or agency after the effective date of the amendatory act that added this section until the health facility or agency complies with subsection (4) or (5), or both. This subsection and subsection (1) do not apply to an individual who is employed by, under independent contract to, or granted clinical privileges in a health facility or agency before the effective date of the amendatory act that added this section.

(3) An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health facility or agency that is a nursing home, county medical care facility, or home for the aged and has received a good faith offer of employment, an independent contract, or clinical privileges from the health facility or agency shall give written consent at the time of application for the department of state police to conduct a criminal history check under subsection (4) or (5), or both, along with identification acceptable to the department of state police. If the department of state police has conducted a criminal history check on the applicant within the 24 months immediately preceding the date of application and the applicant provides written consent for the release of information for the purposes of this section, the health facility or agency may use a copy of the results of that criminal history check instead of obtaining written consent and requesting a new criminal history check under this subsection, and under subsections (4) and (5), or both. If the applicant is using a prior criminal history check as described in this subsection, the health facility or agency shall accept the copy of the results of the criminal history check only from the health facility or agency or adult foster care facility that previously employed or granted clinical privileges to the applicant or from the firm or agency that independently contracts with the applicant.

(4) Upon receipt of the written consent and identification required under subsection (3), if an applicant has resided in this state for 3 or more years preceding the good faith offer of employment, an independent contract, or clinical privileges, a health facility or agency that is a nursing home, county medical care facility, or home for the aged that has made a good faith offer of employment or an independent contract or clinical privileges to the applicant shall make a request to the department of state police to conduct a criminal history check on the applicant. The request shall be made in a manner prescribed by the

department of state police. The health facility or agency shall make the written consent and identification available to the department of state police. If there is a charge for conducting the criminal history check, the health facility or agency requesting the criminal history check shall pay the cost of the charge. The health facility or agency shall not seek reimbursement for the charge from the individual who is the subject of the criminal history check. The department of state police shall conduct a criminal history check on the applicant named in the request. The department of state police shall provide the health facility or agency with a written report of the criminal history check conducted under this subsection. The report shall contain any criminal history record information on the applicant maintained by the department of state police. As a condition of employment, an applicant shall sign a written statement that he or she has been a resident of this state for 3 or more years preceding the good faith offer of employment, independent contract, or clinical privileges.

(5) Upon receipt of the written consent and identification required under subsection (3), if an applicant has resided in this state for less than 3 years preceding the good faith offer of employment, an independent contract, or clinical privileges, a health facility or agency that is a nursing home, county medical care facility, or home for the aged that has made a good faith offer described in this subsection to the applicant shall comply with subsection (4) and shall make a request to the department of state police to forward the applicant's fingerprints to the federal bureau of investigation. The department of state police shall request the federal bureau of investigation to make a determination of the existence of any national criminal history pertaining to the applicant. An applicant described in this subsection shall provide the department of state police with 2 sets of fingerprints. The department of state police shall complete the criminal history check under subsection (4) and, except as otherwise provided in this subsection, provide the results of its determination under subsection (4) to the health facility or agency and the results of the federal bureau of investigation determination to the department of consumer and industry services within 30 days after the request is made. If the requesting health facility or agency is not a state department or agency and if a crime is disclosed on the federal bureau of investigation determination, the department shall notify the health facility or agency in writing of the type of crime disclosed on the federal bureau of investigation determination without disclosing the details of the crime. Any charges for fingerprinting or a federal bureau of investigation determination under this subsection shall be paid in the manner required under subsection (4).

(6) If a health facility or agency that is a nursing home, county medical care facility, or home for the aged determines it necessary to employ or grant clinical privileges to an applicant before receiving the results of the applicant's criminal history check under subsection (4) or (5), or both, the health facility or agency may conditionally employ or grant conditional clinical privileges to the individual if all of the following apply:

(a) The health facility or agency requests the criminal history check under subsection (4) or (5), or both, upon conditionally employing or conditionally granting clinical privileges to the individual.

(b) The individual signs a statement in writing that indicates all of the following:

(*i*) That he or she has not been convicted of 1 or more of the crimes that are described in subsection (1)(a) and (b) within the applicable time period prescribed by subsection (1)(a) and (b).

(*ii*) The individual agrees that, if the information in the criminal history check conducted under subsection (4) or (5), or both, does not confirm the individual's statement under subparagraph (*i*), his or her employment or clinical privileges will be terminated by the health facility or agency as required under subsection (1) unless and until the individual can prove that the information is incorrect. The health facility or agency shall

provide a copy of the results of the criminal history check conducted under subsection (4) or (5), or both, to the applicant upon request.

(*iii*) That he or she understands the conditions described in subparagraphs (*i*) and (*ii*) that result in the termination of his or her employment or clinical privileges and that those conditions are good cause for termination.

(7) On the effective date of the amendatory act that added this section, the department shall develop and distribute a model form for the statement required under subsection (6)(b). The department shall make the model form available to health facilities or agencies subject to this section upon request at no charge.

(8) If an individual is employed as a conditional employee or is granted conditional clinical privileges under subsection (6), and the report described in subsection (4) or (5), or both, does not confirm the individual's statement under subsection (6)(b)(*i*), the health facility or agency shall terminate the individual's employment or clinical privileges as required by subsection (1).

(9) An individual who knowingly provides false information regarding criminal convictions on a statement described in subsection (6)(b)(*i*) is guilty of a misdemeanor punishable by imprisonment for not more than 90 days or a fine of not more than $500.00, or both.

(10) A health facility or agency that is a nursing home, county medical care facility, or home for the aged shall use criminal history record information obtained under subsection (4), (5), or (6) only for the purpose of evaluating an applicant's qualifications for employment, an independent contract, or clinical privileges in the position for which he or she has applied and for the purposes of subsections (6) and (8). A health facility or agency or an employee of the health facility or agency shall not disclose criminal history record information obtained under subsection (4) or (5) to a person who is not directly involved in evaluating the applicant's qualifications for employment, an independent contract, or clinical privileges. Upon written request from another health facility or agency or adult foster care facility that is considering employing, independently contracting with, or granting clinical privileges to an individual, a health facility or agency that has obtained criminal history record information under this section on that individual shall share the information with the requesting health facility or agency or adult foster care facility. Except for a knowing or intentional release of false information, a health facility or agency has no liability in connection with a criminal background check conducted under this section or the release of criminal history record information under this subsection.

(11) As a condition of continued employment, each employee, independent contractor, or individual granted clinical privileges shall agree in writing to report to the health facility or agency immediately upon being arrested for or convicted of 1 or more of the criminal offenses listed in subsection (1)(a) and (b).

(12) As used in this section:

(a) "Adult foster care facility" means an adult foster care facility licensed under the adult foster care facility licensing act, 1979 PA 218, MCL 400.701 to 400.737.

(b) "Independent contract" means a contract entered into by a health facility or agency with an individual who provides the contracted services independently or a contract entered into by a health facility or agency with an organization or agency that employs or contracts with an individual after complying with the requirements of this section to provide the contracted services to the health facility or agency on behalf of the organization or agency.

This act is ordered to take immediate effect.
Approved May 10, 2002.
Filed with Secretary of State May 10, 2002.

[No. 304]

(SB 748)

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending the title and sections 3515, 3519, 3523, 3529, 3801, 3807, 3809, 3811, 3815, 3819, and 3829 (MCL 500.3515, 500.3519, 500.3523, 500.3529, 500.3801, 500.3807, 500.3809, 500.3811, 500.3815, 500.3819, and 500.3829), the title as amended by 1998 PA 457, sections 3515, 3519, 3523, and 3529 as added by 2000 PA 252, and sections 3801, 3807, 3809, 3811, 3815, 3819, and 3829 as added by 1992 PA 84, and by adding sections 224b, 3830, and 3830a; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

TITLE

An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety

companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act.

500.224b Quality assistance assessment fee; assessment on health maintenance organization having medicaid managed care contract; use; circumstances; definitions.

Sec. 224b. (1) The department of community health shall assess on each health maintenance organization that has a medicaid managed care contract awarded by the state and administered by the department of community health a quality assurance assessment fee that equals a percentage established by the department of community health that, when applied to each health maintenance organization's non-medicare premiums paid to the health maintenance organization, totals an amount that would equal a 5% increase for the medicaid managed care program net of the value of the quality assurance assessment fee.

(2) The quality assurance assessment fee collected under subsection (1) and all federal matching funds attributed to that fee shall be used for the following purposes and under the following specific circumstances:

(a) The entire quality assurance assessment fee and all federal matching funds attributed to that fee shall be used to maintain the medicaid reimbursement rate increase

in each fiscal year in which the fee is first assessed. Only a health maintenance organization that is assessed the quality assurance assessment fee is eligible for the increased medicaid reimbursement rates under this section.

(b) The quality assurance assessment fee shall be implemented on the effective date of the amendatory act that added this section.

(c) The quality assurance assessment fee shall be assessed on the non-medicare premiums collected by each health maintenance organization described in subsection (1) in calendar year 2001. If the health maintenance organization did not have non-medicare premium revenue in calendar year 2001, the assessment shall be based on the health maintenance organization's non-medicare premiums collected in the immediately preceding quarter. Except as otherwise provided, the quality assurance assessment fee shall be payable on a quarterly basis with the first payment due 90 days after the date the fee is assessed. However, for a health maintenance organization that did not have non-medicare premium revenue in calendar year 2001, the first quality assurance assessment fee shall be assessed as soon as possible and shall be payable upon receipt.

(d) The quality assurance assessment fee shall only be assessed on a health maintenance organization that has in effect a medicaid managed care contract awarded by the state and administered by the department of community health at the time of the assessment.

(e) Beginning October 1, 2003, the quality assurance assessment fee shall no longer be assessed or collected.

(f) The department of community health shall implement this section in a manner that complies with federal requirements necessary to assure that the quality assurance assessment fee qualifies for federal matching funds. If the department of community health is unable to comply with the federal requirements for federal matching funds under this section or is unable to use the fiscal year 2001-2002 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's medicaid contract with health maintenance organizations, the quality assurance assessment fee under this section shall no longer be assessed or collected.

(g) If a health maintenance organization fails to pay the quality assurance assessment fee required under subsection (1), the department of community health may assess the health maintenance organization a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(h) The medicaid health maintenance organization quality assurance assessment fund is established as a separate fund in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment fee with the state treasurer for deposit in the medicaid health maintenance organization quality assurance assessment fund to be used as provided in subsection (2)(a).

(i) In all fiscal years governed by this section, medicaid reimbursement rates shall not be reduced below the medicaid payment rates in effect on April 1, 2002 as a direct result of the quality assurance assessment fee assessed under this section. This subdivision does not apply to a change in medicaid reimbursement rates caused by a change in covered benefits or change in covered populations required under the state's medicaid contract with health maintenance organizations.

(j) The amounts listed in this subdivision are appropriated for the department of community health, subject to the conditions set forth in this section, for the fiscal year ending September 30, 2003:

MEDICAL SERVICES		
Health plan services	$	1,476,781,100
Gross appropriation	$	1,476,781,100
Appropriated from:		
Federal revenues:		
Total federal revenues		817,495,900
Special revenue funds:		
Medicaid quality assurance assessment		55,747,000
State general fund/general purpose	$	603,538,200

(3) As used in this section:

(a) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(b) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

500.3515 Additional health maintenance services; copayments; "preventative health care services" defined; partial payment from government or private person.

Sec. 3515. (1) A health maintenance organization may provide additional health maintenance services or any other related health care service or treatment not required under this chapter.

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts with nominal copayments that are required for specific health maintenance services. Copayments, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. A health maintenance organization shall not require contributions be made to a deductible for preventative health care services. As used in this subsection, "preventative health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(3) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

500.3519 Contract and contract rates; fairness; rate differential; basic health services required.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles and nominal copayments, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

500.3523 Health maintenance contract; provisions.

Sec. 3523. (1) A health maintenance contract shall be filed with and approved by the commissioner.

(2) A health maintenance contract shall include any approved riders, amendments, and the enrollment application.

(3) In addition to the provisions of this act that apply to an expense-incurred hospital, medical, or surgical policy or certificate, a health maintenance contract shall include all of the following:

(a) Name and address of the organization.

(b) Definitions of terms subject to interpretation.

(c) The effective date and duration of coverage.

(d) The conditions of eligibility.

(e) A statement of responsibility for payments.

(f) A description of specific benefits and services available under the contract within the service area, with respective copayments and deductibles.

(g) A description of emergency and out-of-area services.

(h) A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldfaced type.

(i) Covenants that address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.

(j) Covenants of the subscriber shall address all of the following subjects:

(*i*) Timely payment.

(*ii*) Nonassignment of benefits.

(*iii*) Truth in application and statements.

(*iv*) Notification of change in address.

(*v*) Theft of membership identification.

(k) A statement of responsibilities and rights regarding the grievance procedure.

(*l*) A statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

(m) A statement regarding conversion rights.

(n) Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and the time constraints imposed.

(o) Provisions for grace periods for late payment.

(p) A description of any specific terms under which the health maintenance organization or the subscriber can terminate the contract.

(q) A statement of the nonassignability of the contract.

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments and deductibles directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

500.3801 Chapter; definitions.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

(*i*) For an individual medicare supplement policy, the person who seeks to contract for insurance benefits.

(*ii*) For a group medicare supplement policy, the proposed certificate holder.

(b) "Bankruptcy" means when a medicare+choice organization that is not an insurer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(c) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(d) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the insurer.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) "Creditable coverage" means coverage of an individual provided under any of the following:

(*i*) A group health plan.

(*ii*) Health insurance coverage.

(*iii*) Part A or part B of medicare.

(*iv*) Medicaid other than coverage consisting solely of benefits under section 1928 of medicaid, 42 U.S.C. 1396s.

(*v*) Chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1110.

(*vi*) A medical care program of the Indian health service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 U.S.C. 8901 to 8914.

(*ix*) A public health plan as defined in federal regulation.

(*x*) Health care under section 5(e) of title I of the peace corps act, Public Law 87-293, 22 U.S.C. 2504.

(g) "Direct response solicitation" means solicitation in which an insurer representative does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in section 3 of subtitle A of title I of the employee retirement income security act of 1974, Public Law 93-406, 29 U.S.C. 1002.

(i) "Insolvency" means when an insurer licensed to transact the business of insurance in this state has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any entity, including a health care corporation, delivering or issuing for delivery in this state medicare supplement policies.

(k) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(*l*) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

(m) "Medicare+choice plan" means a plan of coverage for health benefits under medicare part C as defined in section 12-2859 of part C of medicare, 42 U.S.C. 1395w-28, and includes any of the following:

(*i*) Coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(*ii*) Medical savings account plans coupled with a contribution into a medicare+choice medical savings account.

(*iii*) Medicare+choice private fee-for-service plans.

(n) "Medicare supplement buyer's guide" means the document entitled, "guide to health insurance for people with medicare", developed by the national association of insurance commissioners and the United States department of health and human services or a substantially similar document as approved by the commissioner.

(o) "Medicare supplement policy" means an individual or group policy or certificate of insurance that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare and medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations.

(p) "PACE" means a program of all-inclusive care for the elderly as described in the social security act.

(q) "Policy form" means the form on which the policy is delivered or issued for delivery by the insurer.

(r) "Secretary" means the secretary of the United States department of health and human services.

(s) "Social security act" means the social security act, chapter 531, 49 Stat. 620.

500.3807 Basic core package of benefits.

Sec. 3807. Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809 that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

(b) Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

(d) Coverage under medicare parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

500.3809 Additional benefits; reimbursement for preventative screening tests and services; definitions.

Sec. 3809. (1) In addition to the basic core package of benefits required under section 3807, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811(5)(b) to (j):

(a) Medicare part A deductible: coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

(c) Medicare part B deductible: coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the medicare part B excess charges: coverage for 80% of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by medicare.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare.

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Digital rectal examination.

(B) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.

(C) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(D) Serum cholesterol screening every 5 years.

(E) Thyroid function test.

(F) Diabetes screening.

(G) Tetanus and diphtheria booster every 10 years.

(H) Any other tests or preventive measures determined appropriate by the attending physician.

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

(*i*) No more than the number of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(*ii*) The actual charges for each visit up to a maximum reimbursement of $40.00 per visit.

(*iii*) One thousand six hundred dollars per calendar year.

(*iv*) Seven visits in any 1 week.

(*v*) Care furnished on a visiting basis in the insured's home.

(*vi*) Services provided by a care provider as defined in this section.

(*vii*) At-home recovery visits while the insured is covered under the insurance policy and not otherwise excluded.

(*viii*) At-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit.

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, offer new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. These benefits may include benefits that are appropriate to medicare supplement insurance, new or

innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies.

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(3) As used in subsection (1)(j):

(a) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the insured as a place of residence, provided that it qualifies as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's home.

(d) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is 1 visit.

500.3811 Basic core benefits; availability; sale of certain benefits prohibited; designations, structure, language, and format; other designations; requirements.

Sec. 3811. (1) An insurer shall make available to each prospective medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807.

(2) Groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall not be offered for sale in this state except as may be permitted in section 3809(1)(k).

(3) Benefit plans shall contain the appropriate A through J designations, shall be uniform in structure, language, and format to the standard benefit plans in subsection (5), and shall conform to the definitions in this chapter. Each benefit shall be structured in accordance with sections 3807 and 3809 and list the benefits in the order shown in subsection (5). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(4) In addition to the benefit plan designations A through J as provided under subsection (5), an insurer may use other designations to the extent permitted by law.

(5) A medicare supplement insurance benefit plan shall conform to 1 of the following:

(a) A standardized medicare supplement benefit plan A shall be limited to the basic core benefits common to all benefit plans as defined in section 3807.

(b) A standardized medicare supplement benefit plan B shall include only the following: the core benefits as defined in section 3807 and the medicare part A deductible as defined in section 3809(1)(a).

(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 3809(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h).

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j).

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered

expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

500.3815 Outline of coverage; acknowledgment of receipt; substitute; language, format, and required items.

Sec. 3815. (1) An insurer that offers a medicare supplement policy shall provide to the applicant at the time of application an outline of coverage and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

(d) Charts displaying the features of each benefit plan offered by the insurer.

(2) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and shall contain the following statement, in no less than 12-point type, immediately above the company name:

> NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

(3) An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through J letter designation of the plan shall be shown on the cover page and the plans offered by the insurer shall be prominently identified. Premium information shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and method of payment mode shall be stated for all plans that are offered to the applicant. All possible premiums for the applicant shall be illustrated. The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the commissioner:

(Insurer Name)
Medicare Supplement Coverage
Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s)_____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans plus 2 high deductible plans. This chart shows the benefits included in each plan. Every insurer shall make available Plan “A”. Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or, for hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Co-Insurance			x	x	x	x	x	x	x	x
Part A Deductible		x	x	x	x	x	x	x	x	x
Part B Deductible			x			x				x
Part B Excess						x 100%	x 80%		x 100%	x 100%
Foreign Travel Emergency			x	x	x	x	x	x	x	x
At-Home Recovery				x			x		x	x
Drugs								x $1,250 Limit	x $1,250 Limit	x $3,000 Limit
Preventive Care					x					x

PREMIUM INFORMATION

We (insert insurer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change).

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert insurer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do not cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with medicare.

[For direct response issued policies]

(Insert insurer's name) is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local social security office or consult "the medicare handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan offered by the insurer a chart showing the services, medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts pursuant to section 3809(1)(k). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner. The insurer issuing the policy shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$0	$792 (Part A Deductible)
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	$0	Up to $99 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN A
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs

BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	$0	Up to $99 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, in-patient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs

BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs

BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0

First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0

First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—Not covered by Medicare Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

PLAN F OR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as plan F after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as plan F after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0

—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			

First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—			
Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance

—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J OR HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as plan J after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0